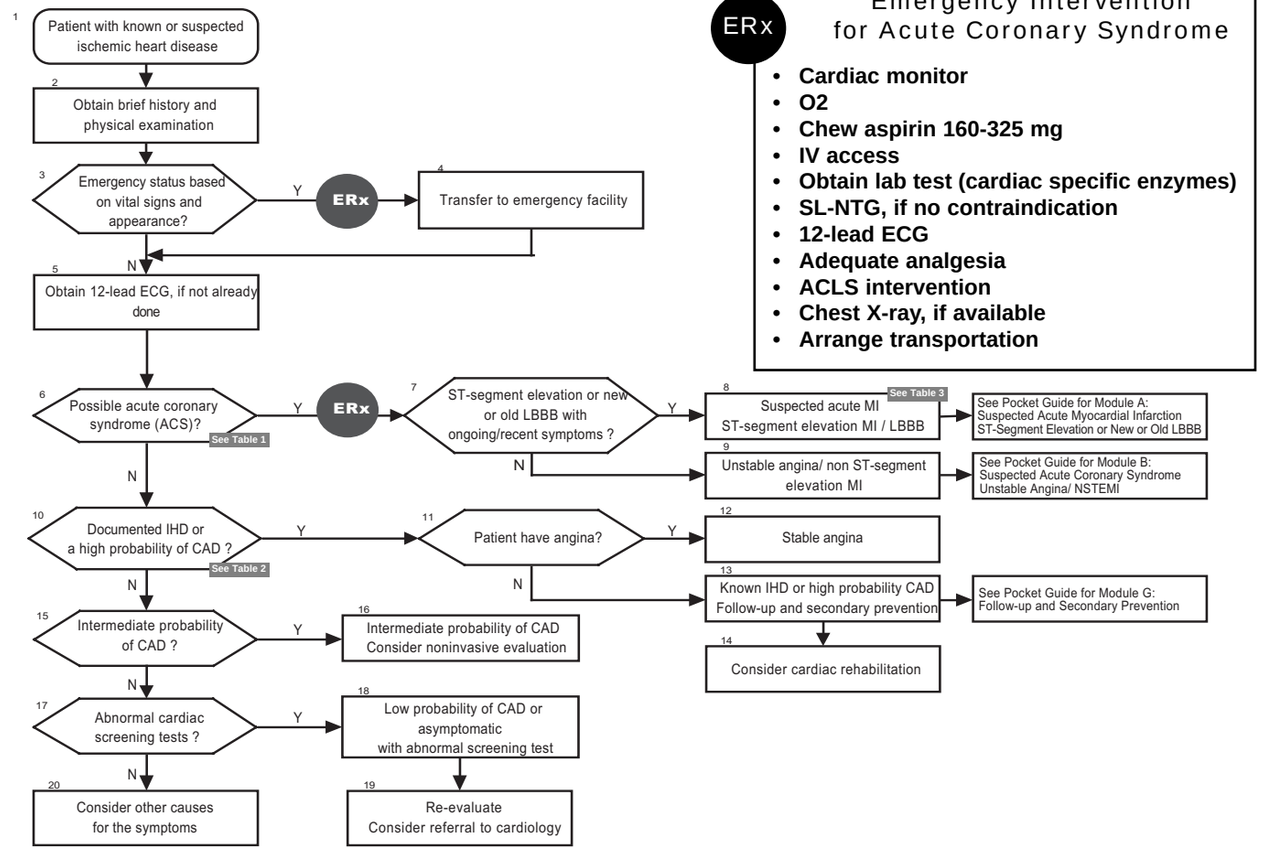
VA/DoD Clinical Practice Guideline
Management of Ischemic Heart Disease (IHD) in Primary Care – Core

Initial Evaluation Pocket Guide

For Management of AMI, Unstable Angina/ NSTEMI & Follow-Up of Patient with IHD
See Respective Pocket Guides



ERx — Emergency Intervention for Acute Coronary Syndrome

- **Cardiac monitor**
- **O2**
- **Chew aspirin 160-325 mg**
- **IV access**
- **Obtain lab test (cardiac specific enzymes)**
- **SL-NTG, if no contraindication**
- **12-lead ECG**
- **Adequate analgesia**
- **ACLS intervention**
- **Chest X-ray, if available**
- **Arrange transportation**

VA access to full guideline: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guideline: http://www.cs.amedd.army.mil/Qmo
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April 2002
NATIONAL CPG COUNCIL

Table 2: Pretest Probability of CAD by Age, Gender, and Symptoms

Age	Gender	Typical/Definite Angina Pectoris	Atypical/ Probable Angina Pectoris	Non-Cardiac Chest Pain	Asymptomatic
30-39	Men	Intermediate	Intermediate	Low	Low
	Women	Intermediate	Intermediate	Low	Low
40-49	Men	Intermediate	Intermediate	Intermediate	Low
	Women	Intermediate	Intermediate	Low	Low
50-59	Men	High	Intermediate	Intermediate	Low
	Women	Intermediate	Intermediate	Low	Low
60-69	Men	High	Intermediate	Intermediate	Low
	Women	Intermediate	Intermediate	Intermediate	Low

"High" indicates >90%, "intermediate" indicates 10% to 90%, and "low" indicates <10%

Table 3: Increased Risk for Complications or Death Following a Myocardial Infarction

- Recurrent angina (spontaneous or inducible)
- Congestive heart failure (CHF)
- Polymorphic ventricular tachycardia, ventricular fibrillation, or sustained monomorphic ventricular tachycardia more than 48 hours from presentation
- Prior MI
- Ejection fraction (EF) <0.40
- Associated severe mitral or aortic valvular disease (e.g., aortic stenosis, aortic regurgitation, or mitral regurgitation)

Pharmacotherapy

Medications	Adverse Reactions	Contraindications
Aspirin: UA/MI 160mg - 325 mg; chronically 81mg -325mg	• GI intolerance: dyspepsia, nausea, GI bleeding, and heartburn • Bronchospasm: especially in patients with a history of asthma/nasal polyps • Tinnitus, Thrombocytopenia, protein-uria/nephropathy	• ASA hypersensitivity: bronchospasm, angioedema, anaphylaxis • Active, severe bleeding
Apsrin Alternative-Clopidogrel: UA/MI 300mg x 1; then 75mg qd	• Neutropenia: was 0.10% versus 0.17% for ASA in the CAPRIE trial. • Bleeding • GI intolerance: diarrhea	• Hypersensitivity to clopidogrel • Active pathological bleeding (GI bleeding and intracranial hemorrhage)

Table 1: DIAGNOSIS OF ACS

A diagnosis of ACS is made if at least *one major criterion* or *at least one minor criterion from both columns I and II* is present

Major Criteria	Minor Criteria	
A diagnosis of an ACS can be made if one or more of the following major criteria is present	In the absence of a major criterion, a diagnosis of ACS requires the presence of at least one item from both columns	
	I	**II**
• ST-elevation[a] or left bundle branch block (LBBB) in the setting of recent (<24 hours) or ongoing angina • New, or presumably new, ST-segment depression (≥0.05 mV) or T-wave inversion (≥0. 2 mV) with rest symptoms • Elevated serum markers of myocardial damage (i.e., troponin I, troponin T, and CK-MB)	• Prolonged (i.e., >20 minutes) chest, arm, or neck discomfort • New onset chest, arm or neck discomfort during minimal exertion or ordinary activity (CCS class III or IV) • Previously documented chest, arm, or neck discomfort which has become distinctly more frequent, longer in duration, or lower in precipitating threshold (i.e., increased by ≥1 CCS class to at least CCS III severity)	• Typical or atypical angina[b] • Male age > 40 or female age >60[c] • Known CAD • Heart failure, hypotension, or transient mitral regurgitation by examination • Diabetes • Documented extra-cardiac vascular disease • Pathologic Q-waves on ECG • Abnormal ST-segment or T-wave abnormalities not known to be new

(a) ST elevation ≥0.2 mV at the J-point in two or more contiguous chest leads V_1, V_2, or V_3; or ≥ 0.1 mV in all other leads. Contiguity in the limb leads (frontal plane) is defined by the lead sequence: aVL, I, inverted aVR, II, aVF, III, aVL.
(b) Use the definitions to determine the likelihood that the presenting symptoms are angina:
(c) These age and gender characteristics define a probability of CAD ≥10% in symptomatic patients

SYMPTOMS THAT MAY REPRESENT ISCHEMIA OR MI

- Chest pain,discomfort, pressure, tightness, or heaviness, defined as at least a one-class
- Radiating pain to the neck, jaw, arms, shoulders, or upper back
- Unexplained or persistent shortness of breath
- Unexplained epigastric pain
- Unexplained indigestion, nausea, or vomiting
- Unexplained diaphoresis
- Unexplained weakness, dizziness, or loss of consciousness

Classification of Symptoms Characteristic for Angina

Typical (definite) angina	IF all three of the following primary symptom characteristics are present: • Substernal chest or arm discomfort with a *characteristic* quality and duration • Provoked by exertion or emotional stress • Relieved by rest or nitroglycerin
Atypical (probable) angina	IF any two of the primary three symptom characteristics are present
Probably non-cardiac chest pain	IF provocation by exertion or emotional distress or relief by rest or nitroglycerin are present and one or more symptom characteristics suggesting non-cardiac pain are present
Definitely non-cardiac chest pain	IF none of the primary symptom characteristics are present and one or more symptom characteristics suggesting non-cardiac pain are present

Symptom characteristics suggesting non-cardiac pain:

- Pleuritic pain (i.e., sharp or knife-like pain brought on by respiratory movements or cough)
- Primary or sole location of discomfort in the middle or lower abdominal regions
- Pain that may be localized at the tip of one finger, particularly over costochondral junctions or the LV apex
- Pain reproduced with movement or palpation of the chest wall or arms
- Constant pain that lasts for many hours
- Very brief episodes of pain that last a few seconds or less
- Pain that radiates into the lower extremities

Canadian Cardiovascular Society Classification of Angina

Class I	Angina only with *strenuous* exertion
Class II	Angina with *moderate* exertion
Class III	Angina with *minimal* exertion or ordinary activity
Class IV	Angina *at rest* or with *any* physical activity